DHS/CC:2 (1/2007)

ADDRESS REPLY TO:

CHILD CARE AND EARLY EDUCATION SERVICE ELIGIBILITY APPLICATION ADDENDUM FORM

STATE OF NEW JERSEY ● DEPARTMENT OF HUMAN SERVICES

Parent/Applicant Name: _____

Social Security Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Date of Birth: ___ ___/___ ___/___ ___

COMPLETE FOR EACH ADDITIONAL CHILD FOR WHOM YOU ARE REQUESTING SUBSIDY

4

FULL Name of CHILD #4: **SOCIAL SECURITY #** **DATE OF BIRTH**

_____ _____ _____ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___/___ ___/___ ___

(Last) *(First)* *(M.I.)* *(9 Digit Number)* *(Mo./Dy./Yr.)*

The following information is required for statistical purposes. Check one or more of the appropriate boxes to indicate response for **CHILD #3**.

RACE: ☐ American Indian or Alaskan ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ White

ETHNICITY: Hispanic/Latino: ☐ Yes ☐ No **SEX:** ☐ Male ☐ Female

Indicate the hour/days/duration for which child care is needed:_____

Child has a special need: ☐ No ☐ Yes ***If yes, state special need and attach verification:***_____

Name of center or caregiver if child is currently enrolled *(To avoid paying higher fees than required, this information may be needed in helping the agency to accurately assess the amount of your co-payment.)*_____

AGENCY USE: Status *(Check One)*: ☐ Denied ☐ Approved ☐ Waiting List ☐ Pending

DYFS USE: (*Enter 8-digit Case #*) KC_____/____

Program: ____ Code: ____ Component: _____ Assessed Co-Payment *(Enter and Circle One)*: $_____ Wk. Mo. Enrollment Date:___ ___/___ ___/___ ___

5

FULL Name of CHILD #5: **SOCIAL SECURITY #** **DATE OF BIRTH**

_____ _____ _____ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___/___ ___/___ ___

(Last) *(First)* *(M.I.)* *(9 Digit Number)* *(Mo./Dy./Yr.)*

The following information is required for statistical purposes. Check one or more of the appropriate boxes to indicate response for **CHILD #4**.

RACE: ☐ American Indian or Alaskan ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ White

ETHNICITY: Hispanic/Latino: ☐ Yes ☐ No **SEX:** ☐ Male ☐ Female

Indicate the hour/days/duration for which child care is needed:_____

Child has a special need: ☐ No ☐ Yes ***If yes, state special need and attach verification:***_____

Name of center or caregiver if child is currently enrolled *(To avoid paying higher fees than required, this information may be needed in helping the agency to accurately assess the amount of your co-payment.)*_____

AGENCY USE: Status *(Check One)*: ☐ Denied ☐ Approved ☐ Waiting List ☐ Pending

DYFS USE: (*Enter 8-digit Case #*) KC_____/____

Program: ____ Code: ____ Component: _____ Assessed Co-Payment *(Enter and Circle One)*: $_____ Wk. Mo. Enrollment Date:___ ___/___ ___/___ ___

6

FULL Name of CHILD #6: **SOCIAL SECURITY #** **DATE OF BIRTH**

_____ _____ _____ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___/___ ___/___ ___

(Last) *(First)* *(M.I.)* *(9 Digit Number)* *(Mo./Dy./Yr.)*

The following information is required for statistical purposes. Check one or more of the appropriate boxes to indicate response for **CHILD #5**.

RACE: ☐ American Indian or Alaskan ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ White

ETHNICITY: Hispanic/Latino: ☐ Yes ☐ No **SEX:** ☐ Male ☐ Female

Indicate the hour/days/duration for which child care is needed:_____

Child has a special need: ☐ No ☐ Yes ***If yes, state special need and attach verification:***_____

Name of center or caregiver if child is currently enrolled *(To avoid paying higher fees than required, this information may be needed in helping the agency to accurately assess the amount of your co-payment.)*_____

AGENCY USE: Status *(Check One)*: ☐ Denied ☐ Approved ☐ Waiting List ☐ Pending

DYFS USE: (*Enter 8-digit Case #*) KC_____/____

Program: ____ Code: ____ Component: _____ Assessed Co-Payment *(Enter and Circle One)*: $_____ Wk. Mo. Enrollment Date:___ ___/___ ___/___ ___

7

FULL Name of CHILD #7: **SOCIAL SECURITY #** **DATE OF BIRTH**

_____ _____ _____ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___/___ ___/___ ___

(Last) *(First)* *(M.I.)* *(9 Digit Number)* *(Mo./Dy./Yr.)*

The following information is required for statistical purposes. Check one or more of the appropriate boxes to indicate response for **CHILD #6**.

RACE: ☐ American Indian or Alaskan ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander ☐ White

ETHNICITY: Hispanic/Latino: ☐ Yes ☐ No **SEX:** ☐ Male ☐ Female

Indicate the hour/days/duration for which child care is needed:_____

Child has a special need: ☐ No ☐ Yes ***If yes, state special need and attach verification:***_____

Name of center or caregiver if child is currently enrolled *(To avoid paying higher fees than required, this information may be needed in helping the agency to accurately assess the amount of your co-payment.)*_____

AGENCY USE: Status *(Check One)*: ☐ Denied ☐ Approved ☐ Waiting List ☐ Pending

DYFS USE: (*Enter 8-digit Case #*) KC_____/____

Program: ____ Code: ____ Component: _____ Assessed Co-Payment *(Enter and Circle One)*: $_____ Wk. Mo. Enrollment Date:___ ___/___ ___/___ ___